MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-72)

03027

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hospital

Stay in hospital or inst. (yrs., or mos., or days): 7 days

Stay in this community (yrs., or mos., or days): 8 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rural near Zion Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: RD 2 North East, Md.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

**3. (a) FULL NAME:** Mary Eliza Alexander

**3. (b) Social Security Number:** none

4. Sex: Female

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~: Arthur Alexander

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1873

**8. AGE:** Years: 66 Months: 3 Days: 3 If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Gabriel Smith
13. Birthplace: Md.

MOTHER
14. Maiden name: no information
15. Birthplace

16. Informant: Arthur Alexander
Address: RD 2 North East, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Mar 31, 1940 (month) (day) (year)

Cemetery or crematory: Trinity

Location: near Zion

18. Funeral director: Florence E. Abernathy
Address: Elkton R.4 5 Md.

19. Mar 30 1940 (Date rec'd by registrar) F. R. Frazer Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28, 1940, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 21, 1940, to Mar. 28, 1940, and that I last saw her alive on Mar. 28, 1940.

Immediate cause of death: Cerebral Accident

Due to: ~~Card~~ Arteriosclerosis with Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

DURATION: 3/19/40

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Mr. Ford H. Spucher, M.D. M. D. or other

Address: Elkton, Md. Date signed: March 29

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APR 4 1940
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

03028

**1. PLACE OF DEATH**

County Cecil Registration Dist. No. 96

Village or City Port Deposit No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Baby Boy Bannon If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year): March 23 1940

7. AGE: Years Months Days — Still Born — If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Port Deposit Maryland

FATHER

13. NAME: Andrew R. Bannon

14. BIRTHPLACE (city or town) (State or country): Port Deposit Md.

MOTHER

15. MAIDEN NAME: May Bell Owens

16. BIRTHPLACE (city or town) (State or country): Perryville Md.

17. INFORMANT (Address): A. R. Bannon Port Deposit Md

18. BURIAL, CREMATION, OR REMOVAL Place: On Premises Date: 3/23, 1940

19. UNDERTAKER (Address): Andrew R Bannon

20. FILED: Mar 23, 1940 Florence W. Sanders Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** March 23, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19 last saw him alive Mar 23, 1940; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Premature (5 mos.) Still Born.

Date of onset

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) B. Benson M. D.

(Address) Port Deposit Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I | | Example II | |
|---|---|---|---|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| *Arteriosclerosis* | *1915* | *Attack of epilepsy* | *1 week ago* |
| *Chronic interstitial nephritis* | *1921* | *Run over by street car* | *1 week ago* |
| *Cerebral hemorrhage* | *July 5, 1927* | *Peritonitis* | *3 days ago* |
| | | | |
| | | | |
| Other contributory causes of importance: | | Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* | *Gastroenteritis* | *1 year* |
| | | | |
| | | | |

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U. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

(93-L)

03029

Reg. Dist. No. 94

**1. PLACE OF DEATH:**
County: Cecil
City or town: Bay View
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days): Lifetime
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Bay View Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: not a veteran

3. (a) FULL NAME: W. Scott Benjamin
3. (b) Social Security Number: none

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Harriett O Benjamin
6(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): April 28 1861
8. AGE: Years 78 Months 10 Days 20 If less than one day ___ hrs. ___ min.
9. Birthplace: Cecil Co Md
(Town, county, and state)
10. Usual occupation: Farmer + Butcher
11. Industry or business
FATHER
12. Name: William Benjamin
13. Birthplace: Maryland
MOTHER
14. Maiden name: Sarah Mahoney
15. Birthplace: Maryland
16. Informant: Dr Frank Benjamin
Address: North East Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 23 1940 (month) (day) (year)
Cemetery or crematory: Bay View Methodist
Location: Bay View, Cecil Co Md
18. Funeral director: Joseph R Grant
Address: North East Md
19. 3/23 1940 (Date rec'd by registrar) Lida V. Owens Registrar
Temp.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1940, at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1937 19__, to March 1940, and that I last saw him alive on Mar 20 1940.
Immediate cause of death: Angina Pectoris
Due to: Chronic Myocarditis, Duration: Unknown
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gregg M Knauf MD M. D. or other
Address: Rising Sun Md Date signed 3/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

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APR 2 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-C)

03030

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County Cecil

City or town New Rising Sun

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Cecil

City or town New Rising Sun Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Wilmer Kurtz Bird

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Bella Bird

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25. 1868

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 22 | hrs. min. |

9. Birthplace Rising Sun. Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Joseph Bird

13. Birthplace New Jersey

MOTHER 14. Maiden name Hannah Thompson

15. Birthplace Md.

16. Informant Mrs. Malva Bird Weir

Address Rising Sun. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March. 20 1940 (month) (day) (year)

Cemetery or crematory Elkton Pa.

Location Elkton Pa.

18. Funeral director J. E. Tyson.

Address Rising Sun Md.

19. 3/18 (Date received by registrar) 1940 W. Pennington Registrar

Permit issued Mch 18. 1940

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1940, at 7.30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1940, to 3/17 1940, and that I last saw him alive on 3/16 1940.

| Immediate cause of death | DURATION |
|---|---|
| Dilatation of Heart | |
| Chronic endocarditis | |
| Due to Rheumatism | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J D Sheen M. D. or other

Address Rising Sun Md Date signed 3/6-40

03031

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(48-E)

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County Cecil County

City or town rural Big Elk
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Elkton RD 3

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Elkton (Rural near Big Elk chapel) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Elsie Blackson

**3. (b) Social Security Number** none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

8 (b) Name of husband or ~~wife~~ Gustavus Blackson

6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) March 2 - 1879

**8. AGE:** Years 61 Months 0 Days 14 If less than one day ___ hrs. ___ min.

9. Birthplace Philadelphia Penna
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name William McKnight
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden name Katherine Jefferies
15. Birthplace New Jersey

16. Informant Gustavis Blackson

Address Elkton 1 P F D #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 20 - 40 (month) (day) (year)

Cemetery or crematory Fernwood (Penna)

Location Philadelphia

18. Funeral director Florence M. Almathey

Address Elkton Md R F D 5

19. Mar 18 1940 (Date rec'd by registrar) F R Frazer Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 16th 1940, at 8:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1938, to Mar 16 1940, and that I last saw her alive on Mar 16 1940.

Immediate cause of death: Acute dilatation of heart

Due to: Chronic valvular heart disease.

Due to

Other conditions: Carcinoma, metastatic of abdominal viscera, from carcinoma of uterus removed at operation 8 yrs ago. Deep X Ray treatment at that time. Reoccurance in last 6 mo in abdominal viscera.
(Include pregnancy within 3 months of death)

~~Major findings~~:
~~Of operations~~:

Of autopsy

DURATION: 12 hrs.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wallace M Johnson M.D. M. D. or other

Address Newark Del Date signed 4-17-40

3-17-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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APR 4 1940
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

03032

Reg. Dist. No. 94

**1. PLACE OF DEATH:**
County Cecil
City or town North East
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town North East Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mamie Tyson Blake
3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Wm K Blake
6(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) Mar. 18. 1866

8. AGE: Years 73. Months — Days 10 If less than one day ___ hrs. ___ min.

9. Birthplace North East Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Thomas Tyson
13. Birthplace North East RD
MOTHER
14. Maiden name Lydia Fields
15. Birthplace North East, R.D. Md
18. Informant T. Kennard Blake
Address North East Md
17. Burial Date thereof Mch 31 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Union Cemetery Md
Location North East. RD
18. Funeral director H. W. Pippin
Address Elkton Md
19. Mch 29 1940 Lida V. Owens
(Date rec'd by registrar) Registrar
Temp.

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1940, at 1030 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1940, to March 28 1940, and that I last saw her alive on March 28 1940.
Immediate cause of death Pulmonary Oedema — DURATION 1 hour
Duration: less than two hours.
Due to Senile Active Pulmonary Congestion — 1½ hrs
Due to Severe nerve-shock and excitement caused by a fire near her residence.
Other conditions She had been perfectly well prior to the fire. [illegible]
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. A. Cantwell M. D. or other
Address North East Md Date signed Mar 29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (I) (T)

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APR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

03033

Reg. Dist. No. 92

**1. PLACE OF DEATH:**
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Near Calvert Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR not a veteran

**3. (a) FULL NAME** George L. Crawford

**3. (b) Social Security Number** 214-18-5720

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Clara Crawford
6(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Dec 8 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 | 5 | 10 | hrs. min. |

9. Birthplace Elkton Va (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business State Road
FATHER 12. Name Scott Crawford
13. Birthplace Elkton, Va
MOTHER 14. Maiden name Morriss
15. Birthplace Elkton, Va
16. Informant Mrs Clara Crawford
Address Rising Sun R D 1 Box 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 21 1940 (month) (day) (year)
Cemetery or crematory Friends
Location Calvert, Md
16. Funeral director Joseph B Frazer
Address North East, Md
19. Mar 20 1940 (Date rec'd by registrar) J. R. Frazer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1940, at 3 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death Fractured Skull & shock — DURATION
Due to Auto Accident
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations Inquest pending
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 3-17-1940
Where did injury occur? Near Rising Sun Cecil Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route 273
Means of injury Injured at work?

23. SIGNATURE John B. Steen Coroner
M. D. or other
Address Rising Sun Date signed 3/19/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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APR 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55 E)

03034

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

**1. PLACE OF DEATH:**

County: Near Earleville

City or town: Cecil Co. Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 16 Years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Near Earleville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Emily F. Darby

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amandus B. Darby

6 (c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Aug. 29th 1866

8. AGE: Years 73 | Months 6 | Days 28 | If less than one day ___ hrs. ___ min.

9. Birthplace: Delaware
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER
12. Name: Francis A. Foster
13. Birthplace: Delaware

MOTHER
14. Maiden name: Jane Veach
15. Birthplace: Cecil Co. Md.

16. Informant: Hilda F. Darby

Address: 603 W. 22nd St. Wilm. Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/40 (month) (day) (year)

Cemetery or crematory: St. Stephens Cemetery

Location

18. Funeral director: John F. Coffage

Address: Cecilton, Md.

19. Mar 28th 1940 (Date rec'd by registrar) Quinn J. Buske Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1940, at 12:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 - 1939, to March 27 1940, and that I last saw her alive on March 26 1940.

Immediate cause of death: Generalized Carcinomatosis

Due to: Primary in lumbar spine.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 8/20/40; 8/20/40

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. R. Cruckley M.D. M. D. or other

Address: Middletown, Del Date signed 3/28/40

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

## CERTIFICATE OF DEATH

03035

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County Cecil

City or town Elkton Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R.F.D 4

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Rural Near Pleasant Hill Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Not named Doyle

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1940

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 0 | 0 hrs. 0 min. |

9. Birthplace Near Pleasant Hill, Cecil Co. Md

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Glenn E. Doyle

13. Birthplace Virginia

MOTHER 14. Maiden name Pearl M. Bartlett

15. Birthplace Virginia

16. Informant Glenn Doyle

Address Elkton, Md. R.D. 4

17. Burial Date thereof March 4, 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory On property

Location

18. Funeral director Buried by father

Address

19. Mar 4 1940 F. R. Frazer

(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1940, to March 4 1940, and that I last saw h alive on 19

| Immediate cause of death | DURATION |
|---|---|
| Born dead | |
| Due to Premature birth at six months | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. T. Morrison, M.D., M. D. or other

Address Elkton, Md Date signed 3-4-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (1)

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (50)

# CERTIFICATE OF DEATH

03036 Wa Bay.

Reg. Dist. No. 96

**1. PLACE OF DEATH:**
County Cecil
City or town Perryville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Perryville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME M. Etta Ewing

3. (b) Social Security Number none

4. Sex female
5. Color or race white
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband ~~or wife~~ Jacob C. Ewing
6(c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) Jan. 18, 1890
8. AGE: Years 50 Months 3 Days 4 If less than one day ___ hrs. ___ min.
9. Birthplace Chester, Delaware Co. Pa (Town, county, and state)
10. Usual occupation House work.
11. Industry or business Own Home
FATHER
12. Name Jesse McCray
13. Birthplace Rising Sun Md.
MOTHER
14. Maiden name Sarah L. McMullen
15. Birthplace Liberty Grove, Cecil Co Md
16. Informant Jacob C. Ewing
Address Perryville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 25, 1940 (month) (day) (year)
Cemetery or crematory Wesley Chapel
Location Havre De Grace R. D.
18. Funeral director Lee A. Patterson
Address Perryville, Md.
19. Mar 23 1940 (Date rec'd by registrar) Florence W. Sanders Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 1940, at 9:15 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 21st 1940, to Mar 22nd 1940, and that I last saw her alive on Mar. 22nd 1940.

Immediate cause of death General Carcinomatosis — DURATION
Due to Carcinoma of Right Breast — 2 yrs
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James H. Bay M. D. or other
Address Havre De Grace Md Date signed 3/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (M)

RECEIVED
APR 3 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH (94a)

03037

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Cecil
City or town Perry Point
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infant give residence of mother)
State Maryland County Cecil
City or town Perry Point Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1172 Ave. D.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR Spanish American

**3. (a) FULL NAME** Thomas Fleming.

**3. (b) Social Security Number** None.

4. Sex: Male
5. Color or race: White
B. (a) Single, married, widowed, or divorced: Married
B (b) Name of husband or wife: Ellender J. Fleming
6(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): Dec. 24, 1880
8. AGE: Years 59 | Months 2 | Days 9 | If less than one day: hrs. min.
9. Birthplace: Londonderry, Ireland (Town, county, and state)
10. Usual occupation: Checker
11. Industry or business: U. S. Supply Depot
FATHER 12. Name: William Fleming
13. Birthplace: Ireland
MOTHER 14. Maiden name: Mary anne Spence
15. Birthplace: Ireland
16. Informant: Ellender J. Fleming
Address: Perry Point, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 6 1940 (month) (day) (year)
Cemetery or crematory: Principio
Location: Principio Furnace, Md
18. Funeral director: Lee A. Patterson
Address: Perryville Md.
19. Mar 4 19 40 Florence W. Sanders
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 4 1940 6:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1940, to Mar 4 1940; and that I last saw him alive on Mar. 4 1940.

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to Cardiac Failure | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley Jr. M. D. or other
Address Havre de Grace Md Date signed 3/4/40

RECEIVED
MAR 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

03038

# CERTIFICATE OF DEATH

Reg. Dist. No. 94

**1. PLACE OF DEATH:**

County: Cecil

City or town: North East
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 7 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Not a Veteran

3. (a) FULL NAME: Laroy. S. Greenwood

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catharine A Greenwood

6(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): April 17 - 1867

8. AGE: Years: 72 Months: 11 Days: 2 If less than one day: hrs. min.

9. Birthplace: Marion, Wayne Co. New York
(Town, county, and state)

10. Usual occupation: Railway Mail Clerk Ret.

11. Industry or business: U. S. Govt

FATHER
12. Name: Ira Greenwood
13. Birthplace: New York.

MOTHER
14. Maiden name: Ann Sherman
15. Birthplace: New York

16. Informant: Mrs Laroy S. Greenwood

Address: North East. Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3 (month) 23 (day) 40 (year)

Cemetery or crematory: Canoga Cemetery

Location: Seneca Co. New York

18. Funeral director: Joseph R. Grant

Address: North East. Md

19. 3-23 (Date rec'd by registrar) 1940 Lida V. Owens Temp. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: March 19, 1940, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1940, to March 19, 1940, and that I last saw him alive on March 19, 1940.

Immediate cause of death: Cardio-Vascular Nerve Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 2 years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. A. Cornwell, M.D. M. D. or other

Address: North East, Md Date signed: Mar 21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 2 1910
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

# CERTIFICATE OF DEATH

03039

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Cecil
City or town Rural Elkton RD 4
(If ontside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 60 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Elkton, R.D 4 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Oneida Letitia Grosh

3. (b) Social Security Number

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 27 1859
8. AGE: Years 80 Months 3 Days 23 If less than one day hrs. min.
9. Birthplace Marietta Pa (Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name William R Grosh
FATHER 13. Birthplace Utica N Y
MOTHER 14. Maiden name Pauline H. Fibbart
MOTHER 15. Birthplace Marietta Pa
16. Informant Mrs Pauline Walter
Address Elkton Md RD 1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mch 21 1940 (month) (day) (year)
Cemetery or crematory Elkton Cemetery
Location Elkton Md
18. Funeral director H. W. Pippin
Address Elkton Md
19. Mar 21 1940 (Date rec'd by registrar) H R Frazer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1940, at 6 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1940 to March 17 1940, and that I last saw h alive on March 16 1940.

Immediate cause of death Cerebral hemorrhage — DURATION 7 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. T. Morrison, M.D. M. D. or other
Address Elkton, Md Date signed 3-21-40

RECEIVED
APR 4 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95C)

## CERTIFICATE OF DEATH

03040

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days): Lifetime
Stay in this community (yrs., or mos., or days): Lifetime

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Pleasant Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Henry F. Henderson
**3. (b) Social Security Number:** none

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: Jane Anne Steele
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 27 1862
8. AGE: Years: 78 Months: 10 Days: 13 If less than one day: hrs. min.
9. Birthplace: Cecil Co. Md (Town, county, and state)
10. Usual occupation: Store Keeper
11. Industry or business: General Merchandise
FATHER 12. Name: Henry Henderson
FATHER 13. Birthplace: Delaware
MOTHER 14. Maiden name: Caroline Connor
MOTHER 15. Birthplace: Delaware
16. Informant: John Henderson
Address: Elkton R.D. # 5
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-14-40 (month) (day) (year)
Cemetery or crematory: Union Methodist
Location: Union Cecil Co. Md
18. Funeral director: Joseph R. Grant
Address: North East, Md
19. Mar 14 1940 (Date rec'd by registrar) F.H. Frazer Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: March 11 1940, at 10:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from not attended to 19, and that I last saw h alive on 19.

| | DURATION |
|---|---|
| Immediate cause of death: acute dilatation of heart | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John B. Slicer coroner
M. D. or other
Address: Elkton Md. Date signed 3/11 1940

RECEIVED
APR 4 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

03041

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Cecil
City or town: Charlestown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insl. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): about 10 years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Charlestown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

**3. (a) FULL NAME:** Katherine R. Lay.

**3. (b) Social Security Number:** None.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female. | white. | Single. |

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 28 1879.

8. AGE: Years: 60 | Months: 5 | Days: 23. | If less than one day: hrs. min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: House wife.

11. Industry or business:

FATHER
12. Name: John P. Lay.
13. Birthplace: Harford County.

MOTHER
14. Maiden name: Margaret Savage
15. Birthplace: Harford County.

16. Informant: George Lay.
Address: Charlestown, Cecil Co. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Mch. 23, 40. (month) (day) (year)
Cemetery or crematory: Angel Hill.
Location: Havre de Grace Md.

18. Funeral director: Pennington & Son.
Address: Havre de Grace, Md.

19. 3-21- 1940 (Date rec'd by registrar) Florence W. Sanders Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1940, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1940, to Mar 21 1940, and that I last saw h er alive on March 21 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemmorhage | 11 Days |
| Due to Hypertension | 10 yrs |
| Due to Chronic Interstitial Nephritis | 15 yrs |
| Other conditions Diabetes Mellitus | 1 yr. |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Louis Wolbert M.D. M. D. or other
Address: Havre de Grace Date signed 3/24/40

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-d)

# CERTIFICATE OF DEATH

03042

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County Cecil

City or town Elkton, (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: North St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 12 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Md County Cecil

City or town Elkton, (If outside city or town limits, write RURAL NEAR and give town) Ward No.

Street No. North Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Euphemia Loomis

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | Wh. | M. Widowed. |

6 (b) Name of husband or wife William Loomis.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 1852.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | 7 | 24 | hrs. min. |

9. Birthplace Springfield Pa. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Colby.

13. Birthplace Penna.

MOTHER 14. Maiden name No Information.

15. Birthplace

16. Informant W. S. Loomis

Address Elkton, Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Mar 31/40 (month) (day) (year)

Cemetery or crematory Corsons Cem't.

Location Salesbury, Md.

18. Funeral director W. W. Pippin

Address Elkton, Md.

19. Mch 30 1940 (Date rec'd by registrar) F. R. Frazer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1940, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1940, to March 27 1940, and that I last saw h alive on March 27 1940.

| Immediate cause of death | OURATION |
|---|---|
| Chronic Myocarditis | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D. M. D. or other

Address Elkton Date signed 3/31/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (I)

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

# CERTIFICATE OF DEATH

03043

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

**1. PLACE OF DEATH:**

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hospital

Stay in hospital or inst. (yrs., or mos., or days): 15 days.

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Principio Furnace Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** George Washington Lynch

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 9 1860

8. AGE: Years: 79 Months: 3 Days: 25 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Lab

FATHER 12. Name: William T. Lynch

13. Birthplace: North East, Md

MOTHER 14. Maiden name: Mary Jane Craig

15. Birthplace: Philadelphia, Pa

16. Informant: Esther Jackson

Address: Perryville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 10, 40 (month) (day) (year)

Cemetery or crematory: Principio

Location: Principio Furnace, Md

16. Funeral director: Lee A. Calhoun

Address: Perryville, Md

19. Mar 7 1940 (Date rec'd by registrar) J R Frazer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1940, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 1940, to March 5 1940, and that I last saw him alive on March 5, 1940.

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of sigmoid | unknown |
| Due to | |
| Due to Peritonitis | |
| Other conditions Intestinal obstruction | Feb 19 1940 |

(Include pregnancy within 3 months of death)

Major findings:

20. Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry J. Davis M.D.

M. D. or other

Address: Chesapeake City, Md Date signed: 3/6/40

RECEIVED
APR 4 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

03044

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days): about 38 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Not a veteran

**3. (a) FULL NAME:** Amelia J. Marple

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband ~~or wife~~: Frank E. Marple

6(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): May 26, 1851

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 9 | 27 | hrs. min. |

9. Birthplace: Philadelphia, Penna.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: No information

FATHER 13. Birthplace:

MOTHER 14. Maiden name: Kate Greeff

MOTHER 15. Birthplace: Not known

16. Informant: Frank E. Marple

Address: North East, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 28 - 1940 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Union, Md

18. Funeral director: Joseph R. Grant

Address: North East, Maryland

19. Mar 26 1940 (Date rec'd by registrar) I H Frazer Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: March 25 1940, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1940, to March 25 1940, and that I last saw h-er alive on March 25 1940.

Immediate cause of death: Cardio-vascular-renal disease — DURATION:

Due to: — DURATION:

Due to: — DURATION:

Other conditions: None — DURATION:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: McClure N. Sprecher M.D. M. D. or other

Address: Elkton, Md Date signed: March 26

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-B)

# CERTIFICATE OF DEATH

03045

Reg. Dist. No. 95

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

County: Cecil

City or town: Near Colora.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rural, Near Colora. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** George W. McVey.

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Matilda McVey.

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): May. 16, 1863

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 10 | 19 | hrs. min. |

9. Birthplace: Liberty Grove, Md.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Samuel McVey.

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary McMaster

15. Birthplace: Md.

16. Informant: Earl McVey

Address: White Hall. Md. CCC Camp.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 3 - 1940 (month) (day) (year)

Cemetery or crematory: Brookview Cem

Location: Rising Sun, Md.

18. Funeral director: J. E. Tyson.

Address: Rising Sun Md.

19. April - 1940 (Date rec'd by registrar) L. M. Worthington Registrar

Permit issued April - 1940

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/20 - 1940, to 3/30 1940, and that I last saw him alive on 3/29 1940

| Immediate cause of death | Chronic nephritis | DURATION |
|---|---|---|
| | | unknown |
| Due to | | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. B. Shuer M. D. or other

Address: Rising Sun Date signed 4/1/1940

VS A15

03046

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County: Cecil

City or town: Union
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): Lifetime

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Union Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: not a veteran

**3. (a) FULL NAME:** Samuel S. Miller

**3. (b) Social Security Number:** None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): June 6 1862

**8. AGE:** Years 77 Months 9 Days 21 If less than one day ___ hrs. ___ min.

9. Birthplace: Union Cecil Co. Md
(Town, county, and state)

10. Usual occupation: Labour

11. Industry or business: Farm

FATHER
12. Name: William A. Miller
13. Birthplace: Md

MOTHER
14. Maiden name: Katherine B. Miller
15. Birthplace: Md

16. Informant: Benjamin Miller
Address: Elkton R.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 29 1940 (month) (day) (year)

Cemetery or crematory: Union, Methodist

Location: Union Md

18. Funeral director: Joseph R. Grant
Address: North East Md

19. Mar 27 1940 (Date rec'd by registrar) F. R. Frazer Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1940, at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1940, to March 27 1940, and that I last saw him alive on March 23 1940

Immediate cause of death: Cardio-vascular-renal disease

Due to

Due to

Other conditions: Myocardial Failure
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Mitford H. Sprecher, M.D.
M. D. or other

Address: Elkton Md Date signed: March 27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 4 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

## CERTIFICATE OF DEATH

03647

Reg. Dist. No. 92

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH**

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Cecilton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** James E. Moore

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Black | |

6 (b) Name of husband or wife: Widowed

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 6 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | Sept 6 | 15 | hrs. min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles Moore
13. Birthplace: Cecilton M. D.

MOTHER
14. Maiden name: Catherine Browne
15. Birthplace: Cecilton M D

16. Informant: Earl Moore
Address: Cecilton Md

17. burial
(Burial, cremation, or removal. Which?), Date thereof April 2, 1940
(month) (day) (year)

Cemetery or crematory: Cecilton

Location: Cecilton M D.

18. Funeral director: H. McPippin

Address: Elkton Md

19. March 30 1940
(Date rec'd by registrar)

F. R. Frazer
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28, 1940, at 11.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 23, 1940, to Mar. 28, 1940, and that I last saw him alive on Mar. 28, 1940.

| Immediate cause of death | DURATION |
|---|---|
| Generalized Arteriosclerosis | |
| Due to | |
| Due to | |
| Other conditions: Myocardial Failure | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Leland V. Strecker M.D.
M. D. or other

Address: Elkton, Md. Date signed March 29

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 93-d

Reg. Dist. No. 96 Benson

03048

# CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**
(a) County Cecil
(b) City or town Liberty Grove
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 82

**2. HOME (USUAL RESIDENCE) OF DECEASED:**
(a) State Md (b) County Cecil
(c) City or town Liberty Grove
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Oliver R. Morrison

3 (b) If veteran, name war

3 (c) Social Security No.

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife S. Frances Morrison

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1857

8. AGE: Years 82 Months 10 Days 9 If less than one day hr. min.

9. Birthplace Rowlandville Cecil Co Md
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Jacob Morrison
13. Birthplace Cecil Co.

MOTHER
14. Maiden Name Elizabeth Hunter
15. Birthplace Cecil Co.

16 (a) Informant Granville Morrison
(b) Address Liberty Grove, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 5, 40 (month) (day) (year)
(c) Cemetery or crematory Harmony Chapel
Location Liberty Grove Md

18 (a) Funeral director Lee A. Patterson
(b) Address Perryville, Md.

19 (a) Mar 4, 1940 (Date rec'd by registrar) (b) Florence W. Sanders Registrar

## MEDICAL CERTIFICATION

20. Date of death March 3 1940, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov- 1939, to March 1, 1940 and that I last saw him alive on Mar 1 - 1940

Immediate cause of death Chronic Myocarditis — Duration 10 yrs

Due to

Due to

Other conditions Gangrene of foot
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. J. Benson M. D. or other
Address Port Deposit Date signed 3/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 (T) (I)

RECEIVED
APR 5 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5-e)

# CERTIFICATE OF DEATH

03049

Reg. Dist. No. 9 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

**1. PLACE OF DEATH:**

County Cecil

City or town Elkton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 days

Stay in this community (yrs., or mos., or days) 28 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Cecil

City or town North East (If outside city or town limits, write RURAL NEAR and give town) Ward No.

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR Not a Veteran

**3. (a) FULL NAME** George W. Owens

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Lida V. Owens

6(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March 18 1864

8. AGE: Years 75 | Months 10 | Days 2 | If less than one day ____ hrs. ____ min.

9. Birthplace Georgia (Town, county, and state)

10. Usual occupation Insurance Agent

11. Industry or business

FATHER 12. Name Richard Owens

FATHER 13. Birthplace Atlanta Georgia

MOTHER 14. Maiden name Julia Carson

MOTHER 15. Birthplace Georgia

16. Informant Lida Owens

Address North East, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Mar 21 1940 (month) (day) (year)

Cemetery or crematory Silverbrook

Location Wilmington, Delaware

18. Funeral director Joseph R. Grant

Address North East, Md

19. Mar 21 1940 (Date rec'd by registrar) F. H. Frazer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1940, at 6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1939, to March 20, 1940 and that I last saw h- alive on March 20 1940

| Immediate cause of death | DURATION |
|---|---|
| Cardiac Failure | |
| Due to Arteriosclerosis | 5 years |
| Due to Chronic Splenic Tumor | 2 months |
| Other conditions: No autopsy - owner | |

Enlarged spleen; benign tumor.

(Include pregnancy within 3 months of death)

Major findings:

20 operations

20 autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. A. Cunnuell M.D. M. D. or other

Address Wilmington, Del. Date signed Mar 21 1940

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

# CERTIFICATE OF DEATH

Jack. 03050

Reg. Dist. No. 46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (I)

**1. PLACE OF DEATH:**
County Cecil
City or town Fort Defosit, Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 50 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(If newborn infant, give residence of mother)
State Maryland County Cecil
City or town Fort Defosit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** George a Poteet

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Mary E. Poteet
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1851

8. AGE: Years 89 | Months 1 | Days 14 | If less than one day hrs. min.

9. Birthplace Little Britton, Lancaster co. Pa
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business day.

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden name Susan Lee
15. Birthplace unknown

16. Informant Malinda Bowman
Address Fort Defosit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13, 40 (month) (day) (year)
Cemetery or crematory Harmony Chapel
Location Liberty Grove, Md.

18. Funeral director Lee a. Patterson
Address Perryville, Md.

19. March 11 1940 (Date rec'd by registrar) Florence W. Sanders Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10 1940, at 2 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 10 1940, to Mar 10 1940 and that I last saw him alive on Mar 5 1940

| Immediate cause of death | DURATION |
|---|---|
| Pneumonia Fatal | 2 mos |
| Due to | |
| Primary Cause: Arteriosclerosis | |
| Due to | |
| Other conditions Senility | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. G. Jack M. D. or other
Address Fort Defosit, Md. Date signed 3/11/40

RECEIVED
APR 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

03051

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County Cecil

City or town Rural Near Elkton,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Elkton, R.D. 3 Md

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Cecil

City or town Rural Near Elkton Ward No. RD 3
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Elkton R.D. 3, Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Walter E. Pryor

**3. (b) Social Security Number** —

4. Sex M.

5. Color or race wh

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lidie Pryor

6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 12/1877

**8. AGE:** Years 63 Months — Days — If less than one day ___ hrs. ___ min.

9. Birthplace Elkton, Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Wm Pryor
13. Birthplace Elkton, Md RD 1

MOTHER
14. Maiden name Josephine Rothwell
15. Birthplace Elkton, Md

16. Informant Mrs Lidie Pryor

Address Elkton RD 3 Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof 3/15/40 (month) (day) (year)

Cemetery or crematory Elkton, Cemt

Location Elkton, Md

18. Funeral director H.W. Pippin Per [illegible] Pippin

Address Elkton, Md

19. Mar 15 1940 (Date rec'd by registrar) F R Frazer Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1940, at 9.15 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 1935, to March 12 1940, and that I last saw him alive on March 10 - 1940.

Immediate cause of death
Cancer
Cardiac Dilatation
Chronic myocarditis
+ Hypertension.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. or other

Address Elkton Md Date signed 3/15/40

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APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

# CERTIFICATE OF DEATH

03052

Reg. Dist. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:** [redacted] Cecil Co. Md.

County

City or town Near Fredericktown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Near Fredericktown Rfd No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Harry L. Redding

**3. (b) Social Security Number** None

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wilamina Redding

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13th 1864

8. AGE: Years 75 | Months 7 | Days 20 | If less than one day: hrs. min.

9. Birthplace Kent Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name James R. Redding

13. Birthplace Kent Co. Md.

MOTHER 14. Maiden name Sarah J. Boulden

15. Birthplace Kent Co. Md.

16. Informant Wilamina Redding

Address Galena Maryland

17. Burrial (Burial, cremation, or removal. Which?) Date thereof 3-9-40 (month) (day) (year)

Cemetery or crematory Galena Cemetery

Location

18. Funeral director John F. Coffage

Address Chestertown Md.

19. Mar 8 1940 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1940, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on 19 , to March 6 1940, and that I last saw him alive on Mar. 6, 1940.

Immediate cause of death Coronary occlusion — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Emerson Houck M.D. M. D. or other

Address Galena, Md. Date signed 3/7/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

# CERTIFICATE OF DEATH

03053

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Cecil

City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Veterans' Administration

Stay in hospital or inst. (yrs., or mos., or days): 3 mos. 13 days

Stay in this community (yrs., or mos., or days): Same

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perry Point Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 227 C. St. N.E.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Spanish American

**3. (a) FULL NAME:** REYNOLDS, Augustine F.

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | Single |

6 (b) Name of husband or wife: --

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 14, 1863

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 2 | 8 | ____ hrs. ____ min. |

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Coppersmith

11. Industry or business: -

FATHER
12. Name: Michael Reynolds - dead
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ann Carroll - dead
15. Birthplace: Ireland

16. Informant: Hospital Records

Address: Removal

17. March 25, 1940 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Ft. Myer, Virginia

16. Funeral director: Pennington & Son
PENNINGTON & SON

Address: Havre de Grace, Maryland.

19. 3-23- 1940. (Date rec'd by registrar) Florence W. Saulsbury Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1940, at 12:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | Unknown |
| Due to | |
| Due to | |
| Other conditions | |
| Coronary Sclerosis | Unknown |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: John B Slicer
JOHN B. SLICER, M.D., Coroner

Address: Rising Sun, Maryland. Date signed 3-22-40

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BUREAU V. S.

03054

# STATE OF MARYLAND—CERTIFICATE OF DEATH

940 CB

**1. PLACE OF DEATH**

County Cecil Registration Dist. No. 92

Village or City Elkton, No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 0 yrs. mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Allen Scull If U. S. Veteran, specify WAR

(a) Residence: No. Ocean City, N. J. St., Ward. Ocean City N. J.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE Wh

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George S. Scull

6. DATE OF BIRTH (month, day, and year) July 13, 1872

7. AGE Years 68 Months 3 Days 8 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Builder

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) New Jersey

FATHER

13. NAME James C. Scull

14. BIRTHPLACE (city or town) (State or country) N. J.

MOTHER

15. MAIDEN NAME Prudence Combell

16. BIRTHPLACE (city or town) (State or country) N. J.

17. INFORMANT Mrs. George Scull (Address) Ocean City, N. J.

18. BURIAL, CREMATION, OR REMOVAL Place Mt. Pleasant, Md. Date Mar 9, 1940

19. UNDERTAKER H. W. Pippin Per. MHP (Address) Elkton, Md.

20. FILED Mar 7, 1940 F. R. Fiazer Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** March 6th, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from March 6 - 1940, to March 6th, 1940

I last saw him alive on March 6th, 1940; death is said to have occurred on the date stated above, at 6 20 p m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Occlusion.

Date of onset

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [signature] M. D.

(Address) Elkton, Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-a)

03055

# CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: George Shade
3. (b) Social Security Number: 123-03-6093

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 11 1871
8. AGE: Years 68 Months 5 Days 6 If less than one day hrs. min.
9. Birthplace: Rising Sun Maryland (Town, county, and state)
10. Usual occupation
11. Industry or business: Laborer
FATHER 12. Name: William Penn Shade
13. Birthplace: Balto, Md
MOTHER 14. Maiden name: Mary Southerland
15. Birthplace: Camden, N. J.
16. Informant: Mrs Emma Ferguson
Address: Rising Sun, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 8, 1940 (month) (day) (year)
Cemetery or crematory: Friends Burial Grounds
Location: West Nottingham
18. Funeral director: H. W. Pippin Per M.H.
Address: Elkton, Maryland
19. Mar 8 1940 (Date rec'd by registrar) F R Frazer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1940, at 1:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1940, to March 6 1940, and that I last saw him alive on March 5 1940
Immediate cause of death: Acute myocarditis — DURATION: ?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. T. Morrison M. D. or other
Address: Elkton, Md Date signed: 3-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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APR 4 1940
BUREAU V. S.

03056

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County Cecil

City or town Elkton ~~Hospital~~

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hosp.

Stay in hospital or inst. (yrs., or mos., or days) 3 weeks

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Outside Rising Sun Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mattie Elizabeth Sipe

**3. (b) Social Security Number** none

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Noah Walter Sipe.

6(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 29 1894.

**8. AGE:** Years 45 | Months 11 | Days 17 | If less than one day ___ hrs. ___ min.

9. Birthplace Halls mills Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Clinton Blackwell

13. Birthplace Tazewell Va

MOTHER

14. Maiden name Victoria Cothen

15. Birthplace North Wilkesbane N. C.

16. Informant Noah Walter Sipe

Address North East R. F. D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19 1940 (month) (day) (year)

Cemetery or crematory West Nottingham

Location Outside Colora Md.

18. Funeral director J. E. Tyson

Address Rising Sun Md.

19. Mar 18 1940 (Date rec'd by registrar) F. R. Frazer Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 16 1940, at 430 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1940, to 3-16 1940, and that I last saw her alive on 3-15 1940.

Immediate cause of death: Chronic Myocarditis

Due to

Due to Arteriovenous & Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE R. C. Dodson MD M. D. or other

Address Rising Sun Md. Date signed 3/17-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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APR 4 1940
BUREAU V. S.

03057

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**

County: Cecil

City or town: Andora
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): Lifetime

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Andora Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: not a veteran

**3. (a) FULL NAME:** Walter M. Spratt

3. (b) Social Security Number: ~~Cas.~~ 245-16-6823 ~~None~~

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ✓

6(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Mar 27 1907

**8. AGE:** Years: 32 Months: 11 Days: 29 If less than one day: hrs. min.

9. Birthplace: Andora Cecil, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: ✓

FATHER
12. Name: Charles H. Spratt
13. Birthplace: Andora, Md

MOTHER
14. Maiden name: Florie Ayers
15. Birthplace: Rock Church, Cecil Co Md

16. Informant: Charles H. Spratt
Address: Elkton RD #5 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 25 1940 (month) (day) (year)

Cemetery or crematory: Sharps

Location: Fair Hill, Md

18. Funeral director: Joseph R. Grant
Address: North Earp Md

19. Mar 22 1940 (Date rec'd by registrar) F R Frazer Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1940, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1940, to March 22 1940, and that I last saw him alive on March 22 1940.

Immediate cause of death: Pulmonary Edema

Due to: Erysipelas

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J Herbert Bates M. D. ~~or other~~

Address: Elkton Md Date signed: 3/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

03058

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Cecil

City or town Elkton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Cecil

City or town North East Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Infant Thompson

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Black | Single |

8 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 - 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Elkton Cecil Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Robert Gant

13. Birthplace Unknown

MOTHER 14. Maiden name Violet Thompson

15. Birthplace New Alexander Pa

16. Informant Violet Thompson

Address North East, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 21-1940 (month) (day) (year)

Cemetery or crematory North East Colored

Location North East, Md

19. Funeral director Jesper R Shaw

Address North East, Md

19. Mar 20 1940 (Date rec'd by registrar) J R Frazer Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 20 1940, at 3 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-20 1940, to 3-20 1940, and that I last saw him alive on 3-20 1940

| Immediate cause of death | DURATION |
|---|---|
| Premature Birth 8 month gestation | |
| Due to Still born. | |
| Due to Premature separation of placenta. | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R L DeDodson M.D.

M. D. or other

Address Rising Sun Md. Date signed 3/20 40

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